

STATE OF MICHIGAN
DEPARTMENT OF LICENSING AND REGULATORY AFFAIRS
OFFICE OF FINANCIAL AND INSURANCE REGULATION
Before the Commissioner of Financial and Insurance Regulation

In the matter of

XXXXXX

Petitioner

File No. 119602-001

v

Blue Cross Blue Shield of Michigan
Respondent

Issued and entered
this 12th day of August 2011
by R. Kevin Clinton
Commissioner

ORDER

I. PROCEDURAL BACKGROUND

On February 16, 2011, XXXXX, on behalf of her minor son XXXXX¹ (Petitioner), filed a request for external review with the Commissioner of Financial and Insurance Regulation under the Patient's Right to Independent Review Act, MCL 550.1901 *et seq.* The Commissioner reviewed the request and accepted it on February 24, 2011.

The Commissioner notified Blue Cross Blue Shield of Michigan (BCBSM) of the external review and requested the information used in making its adverse determination. The Commissioner received BCBSM's response on March 7, 2011.

¹ Born XXXXX.

The issue in this external review can be decided by a contractual analysis. The contract here is BCBSM's *Community Blue Group Benefits Certificate* (the certificate). The Commissioner reviews contractual issues pursuant to MCL 550.1911(7). This matter does not require a medical opinion from an independent review organization.

II. FACTUAL BACKGROUND

The Petitioner is enrolled for health care coverage as an eligible dependent through an underwritten group.

Between October 5 and October 28, 2010, the Petitioner received eight occupational therapy (OT) visits at the XXXXX Center (XXXXX). The charge was \$455.60. BCBSM denied coverage for this care because it was provided in a nonparticipating facility.

The Petitioner appealed BCBSM's denial through its internal grievance process. BCBSM held a managerial-level conference on January 20, 2011, and issued a final adverse determination dated February 1, 2011, upholding its denial.

III. ISSUE

Is BCBSM required to pay for the Petitioner's care at XXXXX?

IV. ANALYSIS

Petitioner's Argument

The Petitioner has been diagnosed with severe oromotor and motor apraxia. According to his mother, XXXXX provides the intensive therapy that the Petitioner needs so he can continue to progress. She states the facility employs the highly qualified therapists needed address the Petitioner's disability.

The Petitioner's mother states XXXXX has tried in the past and continues to try to become a participating provider with BCBSM. She further states that BCBSM has covered OT services at XXXXX for other children with the same disabilities and diagnoses as the Petitioner. The Petitioner's mother is unclear why BCBSM has denied the Petitioner's OT services with XXXXX.

The Petitioner's mother believes that Petitioner's care at XXXXX was medically necessary, was a covered benefit, and is requesting that BCBSM to cover the claim.

BCBSM's Argument

BCBSM states the Petitioner's certificate provides a benefit for OT when provided by a physician. In Section 4 (p. 4.14) it states the following:

We pay physician services for physical therapy, speech and language pathology services, and occupational therapy when provided for rehabilitation.

"Physician" is defined in the certificate (Section 7, p. 7.19) as "a doctor of medicine, osteopathy, podiatry, chiropractic, or an oral surgeon."

However, Section 3 of the certificate (p. 3.26) states:

Physical, occupational and speech therapies are not payable when provided in a nonparticipating freestanding outpatient physical therapy facility, or any other facility independent of a hospital or any independent sports medicine clinic.

It is BCBSM's position that OT must be provided by a participating facility. Since Kaufman is not a participating facility, BCBSM argues its denial was warranted.

BCBSM states that the notes from the managerial-level conference indicate that the Petitioner's mother was "sort of aware" that XXXXX is not registered or participating with BCBSM; she chose XXXXX because she thought it was the best place for her son. BCBSM

indicates she has a right to make that choice. Further, she did not argue that she was misled by BCBSM to believe the care at XXXXX would be covered.

BCBSM does not dispute that the Petitioner has an OT benefit or that his OT was medically necessary. It maintains that the Petitioner did not receive the services from an approved provider under the terms of the certificate and therefore the OT is not a covered benefit.

Commissioner's Review

Under the terms of the certificate, it is clear that outpatient OT is covered when it is provided by a freestanding facility that participates with BCBSM or when it is provided by a physician. Treatment in a freestanding facility that does not participate with BCBSM is not covered.

BCBSM indicated that XXXXX does not have a signed agreement with BCBSM to accept BCBSM's approved amount as payment in full and therefore it is not a participating provider. Nothing in the record shows that XXXXX participates with BCBSM or that the therapy was provided by a physician. Therefore, the Commissioner concludes that the treatment at XXXXX from October 5 through October 28, 2010, is not a covered benefit under the certificate.

The Petitioner's mother indicates that other patients with the Petitioner's diagnosis have received OT at XXXXX which BCBSM has covered. Even accepting that assertion as true, it cannot be the basis for a decision in this case. The Commissioner can only look at the terms and conditions of the Petitioner's certificate to resolve this case.

The Commissioner finds that the Petitioner's OT claims in this case were processed correctly according to the terms and conditions of the certificate.

V. ORDER

BCBSM's final adverse determination of February 1, 2011, is upheld. BCBSM is not required to cover the Petitioner's care at XXXXX Center.

This is a final decision of an administrative agency. Pursuant to MCL 550.1915, any person aggrieved by this Order may seek judicial review no later than 60 days from the date of this Order in the circuit court for the county where the covered person resides or in the circuit court of Ingham County. A copy of the petition for judicial review should be sent to the Commissioner of Financial and Insurance Regulation, Health Plans Division, Post Office Box 30220, Lansing, MI 48909-7720.

R. Kevin Clinton
Commissioner